# Bruce Crawford, M.D. / Patricia Yost, M.D.

***THE FOLLOWING IS NECESSARY FOR BILLING AND COLLECTION AND WILL BE UPDATED ANNUALLY***

**Todays' Date**_____

## PATIENT INFORMATION – SECTION A

**Patient Name**_____ **Birth Date**_____/_____/_____

**Soc. Sec. Number**_____ **Mailing Address**_____

**City**_____ **State**_____ **Zip**_____

**Phone**_____ **Marital Status: S**ingle / **M**arried / **D**ivorced / **W**idowed

**Email**_____ **Preferred Language**_____

**Please circle one for Race and Ethnicity**

**Race:** White / African American or Black / Asian / Pacific Islander / American Indian / Other

**Ethnicity:** Hispanic / Non Hispanic or White **Declined to Report**

**Emergency Contact**_____ **Phone Number**_____

**PreferredPharmacy**_____**Preferred Lab**_____

## POLICY INFORMATION – SECTION B

Insurance Name_____Policy Holders Name_____

Policy/ID Number_____

## POLICY HOLDER INFORMATION – SECTION C

*Please complete only if Policy Holder is NOT Yourself*

**Policy Holders Birth Date:**_____/_____/_____**Policy Holders Soc Sec Number**_____

**MailingAddress**_____**City**_____**State**_____**Zip**_____

## FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges for services rendered to myself. I hereby authorize Bruce Crawford, MD or Patricia Yost, M.D. to furnish my insurance carrier all information which is requested concerning my diagnosis and treatment for payment purposes. I hereby assign to Bruce Crawford, MD or Patricia Yost, MD all monies from my insurance carrier for services rendered. I understand and acknowledge that I am responsible to for my deductibles and charges not covered or not required to be discounted by this agreement.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

GUARDIAN SIGNATURE IF PATIENT IS A MINOR DATE